



**CREC**  
Capitol Region Education Council

RECEIVED

2010 JAN -8 A 11:24

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

**John J. Allison, Jr. Polaris Center  
Outpatient Mental Health Clinic  
For Children and Families**

**474 School Street  
East Hartford, Connecticut 06108  
(860) 289-8131  
Fax (860) 289-8380**

**[www.crec.org](http://www.crec.org)**

1/5/2010

Cristine A. Vogel, Commissioner  
Office of health Care Access  
410 Capitol Avenue, MS#13HCA  
P.O. Box 340308  
Hartford, CT 06134-0308

Dear Commissioner Vogel,

Enclosed you will find the original and 6 copies of Form 2030 for the Polaris Outpatient Mental Health Clinic. The clinic is currently licensed by the CT Department of Children and Families which allows us to treat children up to the age of 19 and their families. Upon your approval, we will be submitting a Certificate of Need application in order to pursue licensure by the CT Department of Health. DPH licensure will allow us to treat the adults of the families we see as well as to provide treatment for the adult segment of the hearing impaired population in CT.

Respectfully submitted,

  
Timothy K. Carroll, LCSW

Director

John J. Allison Jr. Polaris Center  
474 School Street  
East Hartford, CT 06108



**State of Connecticut  
Office of Health Care Access  
Letter of Intent Form  
Form 2030**

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

**SECTION I. APPLICANT INFORMATION**

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full legal name	Capitol Region Education Council (CREC)	
Doing Business As	Outpatient Mental Health Clinic	
Name of Parent Corporation	NA	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	CREC 111 Charter Oak Ave. Hartford, CT 06106	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Timothy K. Carroll, LCSW Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	Timothy K. Carroll, LCSW Polaris Outpatient Mental Health Clinic East Hartford, CT 06108	
Contact Person Telephone Number	1-860-289-8131 ext. 3408	
Contact Person Fax Number	1-860-291-8001	

Contact Person e-mail Address	tcarroll@crec.org	
-------------------------------	-------------------	--

**SECTION II. GENERAL APPLICATION INFORMATION**

- a. Project Title: Polaris Outpatient Mental Health Clinic
- b. Project Proposal: Expand Population Served to Include Adults (currently licensed by DCF to serve children and families), including Adults who are deaf or have hearing loss
- c. Type of Project/Proposal, please check all that apply:

**Inpatient Service(s):**

- ☐ Medical/Surgical      ☐ Cardiac      ☐ Pediatric      ☐ Maternity
- ☐ Trauma Center      ☐ Transplantation Programs
- ☐ Rehabilitation (*specify type*) \_\_\_\_\_
- ☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
- ☐ Other Inpatient (*specify*) \_\_\_\_\_

**Outpatient Service(s):**

- ☐ Ambulatory Surgery Center      ☐ Primary Care      ☐ Oncology
- ☐ New Hospital Satellite Facility      ☐ Emergency      ☐ Urgent Care
- ☐ Rehabilitation (*specify type*) \_\_\_\_\_      ☐ Central Services Facility
- ☒ Behavioral Health (Psychiatric and/or Substance Abuse Services)
- ☐ Other Outpatient (*specify*) \_\_\_\_\_

**Imaging:**

- ☐ MRI      ☐ CT Scanner      ☐ PET Scanner
- ☐ CT Simulator      ☐ PET/CT Scanner      ☐ Linear Accelerator
- ☐ Cineangiography Equipment      ☐ New Technology: \_\_\_\_\_

**Non-Clinical:**

- ☐ Facility Development      ☐ Non-Medical Equipment      ☐ Renovations
- ☐ Change in Ownership or Control      ☐ Land and/or Building Acquisitions
- ☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
- ☐ Other Non-Clinical: \_\_\_\_\_

- d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

X Yes      ☐ No

If you checked "Yes" above, please check the appropriate box below:

- ☐ New (F, S, Fnc)      ☐ Additional (F, S, Fnc)      ☐ Replacement  
☒ Expansion (F, S, Fnc)      ☐ Relocation      ☐ Termination of Service  
☐ Reduction      ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed \$3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes      ☒ No

If you checked "Yes" above, please check the boxes below, as appropriate:

- ☐ New equipment acquisition and operation  
☐ Replacement equipment with disposal of existing equipment  
☐ Major medical equipment  
☐ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code:

474 School Street, East Hartford, CT 06108

g. List each town this project is intended to serve: Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, Cromwell, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hartland, Harwinton, Manchester, New Britain, New Hartford, Newington, Plainville, Portland, Rocky Hill, Simsbury, Somers, Southington, South Windsor, Suffield, Vernon, West Hartford, Wethersfield, Windsor, Windsor Locks.

h. Estimated starting date for the project: January 2010

i. If the proposal includes change in the number of beds provide the following information: **N/A**

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

**SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION**

- a. Estimated Total Project Expenditure/Cost: \$ \$0.00
- b. Please provide the following tentative capital expenditure/costs related to the proposal:

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	\$0.00
Other (Non-Construction) Specify: _____	
<b>Total Capital Expenditure</b>	
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
<b>Total Capital Cost</b>	
<b>Total Project Cost</b>	\$0.00
Capitalized Financing Costs (Informational Purpose Only)	

\* Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

- c. If the proposal has a total capital expenditure/cost exceeding \$20,000,000 or if the proposal is for major medical equipment exceeding \$3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☐ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code  
☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

- d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

e. Type of financing or funding source (more than one can be checked): *N/A*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Applicant's Equity       | <input type="checkbox"/> Capital Lease   | <input type="checkbox"/> Conventional Loan |
| <input type="checkbox"/> Charitable Contributions | <input type="checkbox"/> Operating Lease | <input type="checkbox"/> CHEFA Financing   |
| <input type="checkbox"/> Funded Depreciation      | <input type="checkbox"/> Grant Funding   |  |
| <input type="checkbox"/> Other (specify) _____    |  |  |

#### SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

## SEE ATTACHED

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.
2. List the types of services being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and the target population to be served.
4. Identify any unmet need and describe how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
7. Who will be responsible for providing the service?
8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

Licensed by the DCF, The Polaris Outpatient Mental Health Clinic currently provides individual, group and family therapy to patients in the Greater Hartford Community. The clinic currently has LMFTs, MSWs, and LPCs delivering clinical services. In addition, the clinic also provides Diagnostic Assessments and Medication Management offered by our Licensed Psychiatrist and Licensed APRN. When indicated, the clinic provides psychological testing administered by our staff Licensed Psychologist.

The Polaris Outpatient Mental Health Clinic is proposing to expand services to the adults of the families that we currently treat. At this point, when it is recognized that an adult member of a family would benefit from outpatient mental health treatment, they are referred to another clinic or mental health facility. Serving the adults of the families we see within the Polaris Clinic would allow for more coordinated treatment planning and increased convenience to the families.

In addition, the Polaris Clinic is also looking to expand services to the Adult Hearing Impaired population in need of outpatient mental health services. We currently offer services to children and families who struggle with hearing loss or hearing impairment. Increasingly, we have found that there is little offered to this Adult population and our clinic has clinicians trained in sign language and issues related to this population.

The Polaris Clinic currently is available to patients from the Greater Hartford Community who are under the age of 19. The clinic is staffed to work with bi-lingual (Spanish) patients as well as patients with hearing loss or hearing impairments. The clinic serves those patients and families insured by Medicaid as well as those with private insurance. The current proposal has a target population that would focus on the adults from the families we serve as well as those adults with mental health needs who having a hearing loss or are hearing impaired.

According to the Commission on the Deaf and Hearing Impaired there are nearly 300,000 people in Connecticut who are deaf or have some type of hearing loss. In Hartford County alone, it is estimated that there are over 4000 individuals in Hartford County who are profoundly deaf and over 70,000 individuals who have some hearing loss.

In a report titled Mental Health: A Report of the Surgeon General, 1999, the Surgeon General notes that 15% of all adults and 21% of children and adolescents in the United States use some form of mental health services. Using the most conservative numbers one can predict that over 600 individuals in Hartford County would need mental health services.

Resources for this population are extremely limited. The only listed agencies providing services are Capitol Region Mental Health and the Commission on the Deaf and Hearing Impaired. It is widely recognized that the services offered through these two agencies are grossly insufficient to meet the needs of this population.

This proposal would have a dramatic effect on the health care delivery system in CT – particularly the mental health population that suffers from a hearing loss or hearing impairments. There currently are very few options for this population to receive mental health services. The Medicaid hearing impaired population has even fewer options for

treatment than those with private insurance. A Community Mental Health Clinic, such as the Polaris Clinic, that offers mental health services to the hearing impaired as one of its specialties will make it easier for providers to refer and easier for the patients to access the services that they desperately need.

The Clinic, with its sensitivity to the needs and disparities of the hearing impaired, will also provide a place of comfort and safety. The Clinic will be equipped to meet the needs of the hearing impaired through the trained clinicians but also through environmental awareness to this population. Environmental sensitivity that includes adaptations to the entrance way as well as communication technology will provide patients a welcoming atmosphere where they feel more comfortable.

Services will be provided by CT Licensed Clinicians who are trained and culturally sensitive and capable of working with a bi-lingual (Spanish) population as well as those patients with a hearing loss. When clinically indicated, these clinicians will also work with the patient and a Licensed Prescriber (Psychiatrist, APRN) if there is a need for psychopharmacological intervention.

The payers of this service are the State or Private Insurance carriers. There would be no change in payer when the Clinic serves this expanded population.



**AFFIDAVIT****To be completed by each Applicant**

Applicant: Capitol Region Education Council

Project Title: Polaris Outpatient Mental Health Clinic

I, Don Walsh, CFO  
 (Name) (Position – CEO or CFO)

of Capitol Region Education Council being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that the Capitol Region Education Council and complies with the  
 (Facility Name)

appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Don Walsh  
 Signature

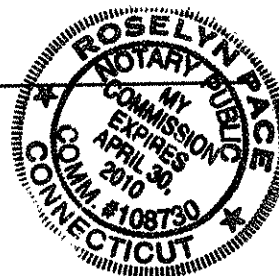
Jan 5, 2010  
 Date

RECEIVED  
 2010 JAN -8 AM 11  
 CONNECTICUT OFFICE OF  
 HEALTH CARE ACCESS

Subscribed and sworn to before me on Tuesday, January 5, 2010

Roselyn Pace ROSELYN PACE  
 Notary Public/Commissioner of Superior Court

My commission expires: April 30, 2010





STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

January 25, 2010

Facsimile Only

Timothy K. Carroll, LCSW, Director  
Capitol Region Education Council  
111 Charter Oak Avenue  
East Hartford, CT 06106

Re: Letter of Intent; Docket Number: 10-31517  
Capitol Region Education Council  
Establish Adult Outpatient Mental Health Services

Dear Mr. Carroll,

On January 8, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Capitol Region Education Council ("Applicant") for the establishment of adult outpatient mental health services in Hartford, with no associated capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hartford Courant* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone".

Kimberly R. Martone  
Director of Operations

KRM:lmg



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

January 25, 2010

Requisition # 30140

Hartford Courant  
285 Broad Street  
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Thursday, January 28, 2010**.

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Steven Lazarus at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone", written over a horizontal line.

Kimberly R. Martone  
Director of Operations

Attachment

KRM:SWL:lmg

c: Danielle Pare, DPH

**PLEASE INSERT THE FOLLOWING:**

Statute Reference:	19a-638
Applicant:	Capitol Region Education Council
Town:	Hartford
Docket Number:	10-31517-LOI
Proposal:	Establish Adult Outpatient Mental Health Services
Capital Expenditure:	\$0

The Applicant may file its Certificate of Need application between March 9, 2010 and May 8, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 410 Capitol Avenue, MS13HCA, P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available at OHCA or on OHCA's website at [www.ct.gov/OHCA](http://www.ct.gov/OHCA). A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

**Greer, Leslie**

---

**From:** ads [ads@graystoneadv.com]  
**Sent:** Monday, January 25, 2010 12:08 PM  
**To:** Greer, Leslie  
**Subject:** Re: Legal Ad Requisition 30140

Good day!

Thanks so much for your ad submission.  
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

2710 North Avenue  
Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061  
E-mail: ads@graystoneadv.com  
<http://www.graystoneadv.com/>

On 1/25/10 11:58 AM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

To Whom It May Concern,  
Please run the attached public notice in the Hartford Courant by 1/28/10. Please refer to requisition **30140** for billing purposes, if you have any questions feel free to call me.

Thank you,

Leslie M. Greer x  
Office of Health Care Access  
A Division of Department of Public Health  
State of Connecticut  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134  
Phone: (860) 418-7001  
Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca) <<http://www.ct.gov/ohca>>



Please consider the environment before printing this message

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
\*\*\*\*\*

TRANSMISSION OK

TX/RX NO 1168  
RECIPIENT ADDRESS 98602918001  
DESTINATION ID  
ST. TIME 01/25 17:36  
TIME USE 00'28  
PAGES SENT 4  
RESULT OK



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: TIMOTHY K. CARROLL, LCSW

FAX: (860) 291-8001

AGENCY: CAPITOL REGION EDUCATION COUNCIL

FROM: STEVEN LAZARUS  
1/25/10

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

NUMBER OF PAGES: 4  
*(including transmittal sheet)*

Comments: Docket 10-31517

**PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.**